

MISSOURI COMMISSION ON PATIENT SAFETY  
MEETING MINUTES

Feb. 4, 2004

10 a.m. – 4 p.m.

Department of Health and Senior Services Bldg  
Jefferson City, Missouri

# OFFICIAL

**Commissioners in attendance: Gregg Laiben, Thomas Cartmell, Susan Kendig, Nancy Kimmel, Alan Morris, Kathryn Nelson, Bea Roam, William Schoenhard, Barry Spoon, James Utley, Kenneth Vuylsteke, Lori Scheidt, and Tina Steinman.**

## I. CALL TO ORDER

Dr. Gregg Laiben, Chairperson

The meeting was called to order at 10:10 AM. Silent roll call was taken.

### Review of Draft Minutes from the previous meeting:

There were no comments or corrections noted. Dr. Morris moved to approve the draft minutes. Mr. Schoenhard seconded the motion. The draft minutes were approved.

### Housekeeping items:

Today's meeting will consist of two presentations and commission discussion. Handouts have been distributed that correspond to the presentations.

Linda Bohrer alerted commissioners to several articles that have been posted to the commission web page in the last two weeks. Commissioners were encouraged to review those articles. One article is related to compensation to medical providers for appropriate corrective actions.

The audience was asked to sign in, and to indicate if they wished to address the Commission.

## II. PRESENTATION ON PATIENT COMPLAINTS AND MALPRACTICE RISKS

Dr. Gerald Hickson, Associate Dean for Clinical Affairs and Director of the Vanderbilt Center for Patient and Professional Advocacy, has researched medical malpractice issues for

20 years. He presented on his research into the correlation between unsolicited patient complaints and the likelihood of a doctor being the subject of medical malpractice litigation. Dr. Spoon is involved with an extension of Dr. Hickson's intervention techniques at St. John's Hospital in Springfield.

Dr. Hickson used his slides as a starting point and provided considerable additional information through his oral presentation. Important points include:

- Safety is related to medical malpractice. People fear addressing safety due to the possibility of medical malpractice litigation. That fear must be addressed in order to improve patient safety.
- The US is experiencing its 5th medical malpractice insurance crisis, and the 6th will strike in 2016 or 2018 unless there are fundamental changes in the insurance markets.
  - Medical malpractice insurance is like any other type of insurance in that it is prone to cycles. Periods of low premiums and aggressive market development are followed with periods of market consolidation, reduced supply and rapidly increasing premiums.
  - The current crisis has been exacerbated by the coincident collapse of the stock markets, the tool most insurers rely on to grow cash reserves when premiums are insufficient to cover losses.
  - Another aggravator has been rising jury awards. Efforts to improve patient safety can ameliorate the magnitude of the natural insurance cycles to the extent that reasons for high jury awards are addressed.
  - Finally, the publicity given to medical errors that has accompanied the current crisis makes this crisis seem different.
  - The current crisis is 2 or 3 years from the likely end of the period of high premiums and reduced supply.
- Solid research on medical malpractice issues is not abundant, even though there are more studies today than existed 20 years ago. In the early 1980's, there were anecdotal literature only, not reliable scientific studies. The intervening decades have seen several large reputable studies conducted. Today's presentation will include a discussion of those studies with acknowledgement of their methodological weaknesses.
- Estimates published by the Institute of Medicine on the number of deaths due to medical errors and the associated costs are not necessarily correct. The IOM's estimates were based on some of the more recent studies, and methodological weaknesses may overstate the magnitude of error.
- Previous studies relied on chart reviews for purposes of identifying when a medical error had occurred.
  - These studies suggest that 4% to 6% of hospital stays result in a medical error, and that of those, 1% to 2% were actually due to negligence.

- Review of actual litigation for the same period and group of charts shows that, of the small fraction of hospital stays where a medical malpractice claim appeared to be valid, only 2% were associated with an actual claim.
- The body of actual claims was 5 to 7 times more likely to be associated with a hospital stay where there was no apparent error, or if there was an error, it was not clearly due to negligence.
- These results are the basis for the IOM's estimate on the number of errors and deaths.
- Dr. Hickson's study in part attempted to replicate these results. However, when a record is reviewed by more than one clinical peer, 50% of the time, clinical peers cannot agree on whether or not an error had occurred. If more than two reviewers are required to agree on the existence of an error or negligence, the numbers of people estimated to be hurt or killed due to medical errors drops to one fifth of what previous studies suggested.
- Doctors are not trained to see eye to eye and do not often agree on what the correct or incorrect care is in any given situation. When confronted with a jury award or settlement for allegedly negligent care, doctors are often confused as to why there was any problem with the care provided.
- The science to deal with this variability of perception is not well developed. Courts are not well equipped to find error or distinguish injury from normal chance of a poor outcome.

Q: Were these studies based purely on review of medical records?

A: Yes, and that's a legitimate criticism of the study methodology. Other studies have been conducted using active surveillance. 17% of patients in these studies are identified as suffering iotrogenic events. So pronouncements about the rate at which people are injured and killed by hospitals should be taken skeptically, due to the variability in the estimates.

- Previous studies focused on questions of how many people were injured due to medical negligence, and of those injured, how many actually filed suit. Dr. Hickson's research investigated why people sue, whether or not a doctor's likelihood of being sued is solely a matter of random chance, and if not random chance (the studies show that it's **not** random), what doctors can do to decrease their risk of being sued.
  - Dr. Hickson stressed that on the issue of why people sue, patients will provide this information if listened to.
  - It is difficult to access data on the risk of being sued. Dr. Hickson utilized data from the Florida Department of Insurance because for a while, Florida had a unique reporting requirement. Medical malpractice insurers were required to report to the Florida DOI on any claims filed against their insureds. This data identified the insureds, the outcome of the action and the size of the award or settlement, if any. (NOTE: Missouri has the same requirement.)
- Using the Florida DOI data, Dr. Hickson's research suggested about 6 core reasons for why people sue:
  - 60% of the time whe another person advised to sue, the other person is another doctor.
  - They need the money; often they don't sue until they start getting collection notices from medical providers for unpaid bills.

- Affluence, a high level of education and previous experience with an attorney appear to be the defining characteristics, rather than actual economic need. Studies are looking at whether affluence makes a person more likely to take their complaint all the way to court or if it just makes it easier for a person to get an attorney. Early indications are that the latter is the driving factor.
- Some sued because they wanted better information. Some are not prepared for the normal risk of an adverse outcome of otherwise technically excellent care.
- New Zealand has moved to a no-fault or "blame-free" system for health care delivery. Some families now pursue criminal action against doctors because the option of pursuing medical malpractice action has been closed. Some people desire more than money when they sue doctors. There is a need for information and validation.

Q: Was the advertising of lawyers ever a factor for why people sued?

A: This question was asked, and the answers were dropped from the data. Two entire pages of the patient survey asked about pressure or influence from "ambulance chasers." Only one instance was found. The study would have to be repeated to see if any recent increase in the amount of advertising has changed the reasons why people sue.

- The Florida DOI data was also used to examine if the chance of being sued was random, or if some doctors were more likely to be sued than others.
  - Doctors seem to fall into 3 categories: those who are never sued, those who encounter the occasional lawsuit, and those that are repeatedly sued.
  - The high-risk group consists of primarily internists, OBs and surgeons. This group accounts for 75% to 85% of awards and settlement costs.
  - Subsequent studies on different sets of the Florida data show similar results.
- Based on these results, Dr. Hickson investigated why some doctors experience more malpractice claims than others.
  - The evidence supported two hypotheses for why doctors are sued: specialty and ability to connect with the patient.
  - Using just OBs, evaluation of those with a high-risk case-mix index and those with a low risk case-mix index showed no difference in likelihood of being sued.
  - Using just OBs, evaluation of those exhibiting technical competence and those exhibiting technical deficiencies showed no difference in likelihood of being sued.
  - Using just OBs, evaluation of those who were the frequent subject of complaints about access and communication showed a strong correlation with those who were ultimately sued.
- Dr. Hickson concludes from this that, while reducing error is important, it will not solve the medical malpractice crisis.
  - People who were actually injured often do not file suits
  - Suits do not address a doctor's ability to communicate effectively with a patient, because the doctor receives no feedback about the actual reasons people are compelled to sue.
  - Risk management cannot fix the medical malpractice crisis because it addresses only one issue at a time.

- When the study of Florida data was concluded, Dr. Hickson asked the participating doctors if they knew their own level of risk. Most of the high-risk doctors did not identify themselves as such.
- Valid criticisms of Dr. Hickson's study are that the sample size was too small and that chart reviews are prone to a given level of inaccuracy.
- Dr. Hickson used this study to investigate what can be done to raise the awareness of high-risk doctors and to see what kind of strategies can be used to lower the risk of litigation.
- Med mal claims data are not useful because they are too infrequent. Doctors can easily argue that the litigation they experienced was unusual and/or frivolous. Complaint data is much more frequent and is also measurable across clinical peers.
- Study of complaint data and risk management data at several institutions showed a correlation between doctors that generated high numbers of complaints, and doctors that generated high numbers of med mal claims. Further study showed that the number of patients seen and the gender of the doctor were not accurate predictors of med mal claims. Accurate predictors were the specialty and the number of complaints generated. Therefore, all doctors at an institution can be scored on their specialty and the number of complaints they generate. These scores can be used as predictors of med mal claims. These doctors are not typically aware of who they are or the risk category they fall into. They need to know and an intervention needs to be designed that will move them out of the group of high-risk doctors.
- Getting the message to these doctors is extremely difficult. The message must come from a clinical peer who is not an authority figure. The messenger must be trained and prepared to deal with the predictable reactions of doctors being told for the first time that they are "high-risk". It should be noted that the initial response of a doctor is a poor predictor of how well that doctor will ultimately respond to intervention.
- Reclaiming high-risk doctors is important because of the amount of resources society has invested in them and the amount of future expense they represent.
- Doctors tend to respond best to data, and pictorial representations that show how they compare to peers is also persuasive.
- As of the date of this meeting, over 400 interventions have been completed, up from 300 stated in the handout. 50 more are scheduled for next week.
- Messengers provide feedback data to the researchers that will help show how well the interventions are working. Hostility seems to be the most common response from target doctors.

Q: What do you define as a "hostile" response?

A: Threatening body language, invitations to leave the office, physically acting out by throwing things or banging on things.

Q: How do you get doctors to volunteer to be your messengers?

A: Researchers at Vanderbilt assumed it would be difficult to get volunteers, but it has not been. Messengers need to be informal leaders in their group or organization. They must be totally committed to confidentiality and professionalism. Messengers must not have any kind of bad history with the target doctor. This cropped up as a problem on one occasion, where the messenger would not admit to previous bad blood.

- When providing assurances to target doctors that the intervention is based on totally objective data, it's fair to acknowledge that the data misclassify about 13% of

doctors. For example, many complaints about ER doctors come from patients seeking inappropriate access to narcotics. However, it's also important to communicate that the interventions are designed to deal with variations where variation is found, regardless of the reason for variation.

- 65% of target doctors respond well to simply being made aware of their status as relatively high risk, and the types of complaints they tend to generate. A good response is a doctor whose risk score falls into more average ranges within a four-year period. In other words, their risk of being sued becomes not significantly different from the risk of their peers.

Q: Is the intervention just sharing data?

A: That's a Level 1 intervention. The target doctor's data with regard to the rate and type of complaints is shared, relative to his or her peers. 30 to 35% of doctors will need a Level 2 intervention in order to reduce their risk.

- A Level 2 intervention is when an authority figure intervenes. For Vanderbilt, this person is the Dean of the medical school. A committee has to agree that Level 2 is needed. The authority figure has been given zero information up to this point about which doctors are considered by the researchers to be high risk. The authority figure and the target doctor work out a written plan together.

Q: Do authority figures truly have no idea until a Level 2 intervention which doctors are a problem?

A: Some do and some are totally clueless.

Q: Is the written plan something the researchers and the authority figure can negotiate? What if the authority figure's idea of a plan is inappropriate?

A: All the researchers do is provide data on whether or not the plan is working over time. The authority figure has to be committed to reclaiming target doctors and also has to actually exercise their authority.

- Researchers have been asked if a single complaint ever merited intervention. Common sense indicates that there are always single egregious events that must be dealt with on their own. That's called risk management. These situations then become part of the data used to score a doctor over time.
- Sometimes there is no ability to respond. That possibility must be dealt with and constitutes a Level 3 intervention. This is enforcement of the organization's policies with regard to doctors that the organization no longer wishes to do business with.

Q: How do you handle this with regard to that doctor's references for future employment?

A: Fortunately or unfortunately, that situation has not yet actually occurred. People tend to leave voluntarily before Level 3 is reached.

Q: But isn't this a moral issue to the extent you risk ruining that doctor's future?

A: Of course it is, but consider the broader perspective. The data show that that if a doctor is a problem in one institution, he or she is going to be a problem no matter where they go.

Q: We know that poor communication between a doctor and a nurse is predictive of medical error. Is poor communication with patients predictive of poor communication with nurses and therefore error?

A: Based on the pilot program data, maybe everyone should either be trained to communicate better or should be partnered with good communicators. This might look expensive in the short run (for example, following one doctor's rounds or appointments with another doctor who is better at communicating with and listening to patients), but maybe in

the long run it's more cost effective. Additional studies are in progress to assess the possible best solutions. However, it's not true that having good relationships with patients equates to having good relationships with other medical providers, and vice versa. A doctor can be a big hit with patients but be poorly thought of by peers. Event reporting systems are being used to assess this issue.

Q: Is the pilot project looking at the difficulty in recruiting messengers in situations where there's nothing in it for the messenger? For example, wouldn't it be much harder outside of a group practice or a teaching institution to get one doctor to voluntarily tell another doctor that something's wrong? Wouldn't the messenger feel much more reluctant to risk a personal and professional relationship when there's no corresponding economic reason for the messenger to want to see the target doctor improve, as when the cost of med mal claims is shared among a group?

A: Two things must be present for messengers to agree that the risks are worth the effort: Training and data. Messengers are certainly set up for failure if they are not adequately trained to deal with predictable negative reactions. Without training, encounters tend to fall into two categories: apologies or volcanoes. Turnover in the pilots has been about 1 out of 10 messengers that just can't continue to provide the interventions. This is relatively low because doctors recognize this as a tool that can be applied to other problems. (Dr. Hickson suggested that Dr. Spoon would have good comments to add, based on his experience.)

Dr. Spoon added that in his experience, people recognize and respond to the need to have these interventions. Peers dealing with peers is an intuitively appealing process. The method of intervention is effective due to the confidentiality. No target doctor knows who the other target doctors are, and non-target doctors don't know who the target doctors are.

- Another issue is bringing this kind of awareness, and how to cope with each other professionally, into early training. There could be improvement in Medical schools in teaching doctors how to deal with other medical professionals. Lawyers do a magnificent job of keeping professional disagreement separate from personal issues. Vanderbilt is putting professional conduct and "talk-back" or message confirmation into the classrooms.

Q: How often do interventions uncover genuine psychiatric problems, and how often are complaints due to cultural differences between patients and foreign doctors?

A: Both are issues that have been encountered. With regard to psychiatric issues, Level 2 interventions can involve "Physician Wellness" programs. They often involve anger management training. Only a very few target doctors have been found to have actual mental illness. Two substance abuse cases have been encountered. There was one case of sexual battery that couldn't be resolved. With regard to culture, we now have sufficient regional variation in the pilot programs to start examining this. One issue is getting a culturally compatible messenger for the target doctor.

Q: Are the pilot institutions all group practices? This commission needs to deal with the entire spectrum of care. How do you get complaint data from private practices?

A: We acknowledge our scope is narrow. Complaint data is available for doctors in private practice but these model interventions were not designed with private practices in mind.

Q: Patient satisfaction surveys are generally understood to be of limited reliability. In your opinion, is there a satisfaction survey tool that might be useful for gathering predictive complaint information?

A: While satisfaction surveys are prone to problems that make them non-predictive for purposes of complaints and med mal claims, there are ways to use them. A survey that has ample space for handwritten notes would be more predictive than a survey that solicited no unstructured comments. In order for the risk of med mal claims to be reduced, doctors must have a mechanism that allows patients to talk back.

This concluded Dr. Hickson's presentation and the discussion. It was noted that Ken Vuylsteke had a question that he could not ask because he had to temporarily leave the meeting. If possible, someone would try to track Ken down and give him the opportunity to ask his question(s) during the lunch break before Dr. Hickson had to leave.

Dr. Laiben asked Dr. Hickson, what should this Commission recommend to the Governor, in your opinion?

A: The easiest and most obvious recommendation is to **tackle safety and medical malpractice in the educational process. Missouri's public medical schools should be charged with training their students in safety issues.** Florida accomplished this with a tax on providers, using the tax revenues to establish centers of excellence. Another recommendation is to **find creative ways to bring patients into the process of care.** Regulators can't accomplish this. Peers must do it. **There must be protection of complaint data** so providers can learn from it. But don't protect it if you're not going to do something with it. **Protection must be predicated on a duty to use the information to improve safety.**

MDI staff are exploring the possibility of creating a more verbatim record of Dr. Hickson's presentation.

Broke for lunch at 12:15 and reconvened at 1:10.

### III. PRESENTATION ON THE LEAPFROG GROUP

Louise Probst, Executive Director of the St. Louis Area Business Health Coalition

A booklet prepared for legislators about the Leapfrog group was distributed. Ms. Probst used slides to present information and prompt discussion. Additional speaking points were:

- The errors discussed in the Institute of Medicine's 1999 report are problems that have been known about for a long time. In response to the IOM report, employers and purchasers of healthcare decided they would use their purchasing power to try to improve quality in medical care.
- The Robert Wood Johnson Foundation is distributing grants to projects intended to lead to a more ideal health care delivery system than currently exists in the US.
- Employers can relate to improving quality by correcting systems errors. The Leapfrog initiatives are systems-based. This is the role employers were asked to play in the IOM's report.
- It costs nothing to be a member of the Leapfrog Group. Members are asked to show their commitment by working on committees and helping to spread Leapfrog's

message. Member organizations include businesses, labor unions, advocacy groups and health plans.

- Member employers agree to Leapfrog Group's purchasing principles. In particular, members are encouraged to find ways to reward excellence in health care.
- Although net cost savings are projected as a result of adopting computerized physician order entry systems, that savings does not tend to accrue to the hospitals that pay for such systems. This can be a disincentive for investment by the hospital.
- In response to criticisms about the expense of staffing ICUs with physicians, Leapfrog points to emergency rooms. ERs are staffed with doctors. Leapfrog asks, why not ICUs? However, Leapfrog broadened its definitions in response to concern about an insufficient number of physicians to accomplish the leap to physician staffed ICUs.
- Leapfrog knows that volume is not a perfect predictor of quality in healthcare settings. Employers have wanted risk-adjusted health care quality measures forever, but the data simply doesn't exist. Pushing the use of volume measures is one way employers are applying their purchasing power to encourage the medical industry to try to find a better way to measure quality.
- Leapfrog adjusts its quality measures every year in order to make up for the dearth of research on outcomes-based quality measures.
- Leapfrog recognizes healthcare institutions that choose to focus on American Hospital Association or CMS quality initiatives, instead of Leapfrog's initiatives. This is because both AHA and CMS quality initiatives involve the transfer of information to the consumer.
- Leapfrog doesn't pressure rural hospitals to participate, but welcomes them if they are willing.
- If the "Leaps" are implemented nationally, they stand to be well worth the effort.
- National Leapfrog standards are implemented one community at a time. Members in rollout communities meet with local hospitals and invite them to participate. Participating hospitals provide data to private, protected central data warehouses.
- The Leapfrog survey takes about a day for a hospital to complete.
- The participation rate in St. Louis is up to 26% as of this date, from the 21% stated in the slide handouts.
- In some communities, participation is 100%. Some government entities actively support participating in Leapfrog.
- Leapfrog's goal is not instant perfection. The goal is improvement over time.
- Member employers and health plans include safety proposals in their contracts with medical providers. All major health plans are Leapfrog members.
- Union contracts call for higher cost sharing if employees go to non-participating hospitals, or to participating hospitals that are not meeting the Leapfrog standards.
- Research from the Rand Institute indicates that 50% of wrong care is delivered on an ambulatory basis. That's why future Leapfrog standards are targeted at clinics and physician offices.
- Physicians are very tech savvy and adapt to new technology quickly once they are convinced of the benefit.

## DISCUSSION:

Q: Why aren't Leapfrog's standards more outcomes oriented, instead of process oriented? State the outcome you want, and let providers come up with processes that work in each unique situation.

A: Leapfrog is working on more outcomes-oriented standards. It's important to remember that Leapfrog is only two years old. The important thing is to get consumers' attention, and start making informed purchasing decisions. Also, Leapfrog asks employers to reward quality care with payment. While Leapfrog standards are several steps away from collecting clinical outcomes data, all standards are based on sound medical research literature.

Q: Will Leapfrog move to publicizing expected outcomes instead of volumes?

A: Hopefully. LEAPFROG is well aware of the limitations of volume as a standard of quality. Outcome data currently tends to be too old to be useful by the time it's made public. Leapfrog feels the best alternative is to rely on adoption of proven processes.

Q: So, LEAPFROG will accept outcomes instead of volume?

A: Yes.

Q: Regarding Computerized Physician Order Entry (CPOE), institutions have found that alone it is not an effective way to improve safety. Surely, employers don't want institutions to waste money on bad systems. Does LEAPFROG hear these kinds of criticisms?

A: Yes. Ideally, LEAPFROG would like fully computerized medical records. But the pushback would be much worse if LEAPFROG tried to push this as the standard. CPOE is seen as an intermediate step.

Response: But the literature is filling up with stories that show the downside to adopting CPOE for the sole purpose of getting the Leapfrog stamp of approval.

Q: What is LEAPFROG's mindset?

A: CPOE is viewed as a beneficial first step. LEAPFROG commissioned a study to compare CPOE vendors and publicize that information for hospitals to look at.

Q: Is Leapfrog encouraging payers to provide the funds to accomplish the standards?

A: Yes.

Q: Beyond the cost of the system, the cost of training on CPOE is high. Even some urban medical centers can't do it. Aren't you pushing out small hospitals from the market place by requiring exorbitant expenditures?

A: Look at it from the patient and clinical perspective. Payers are looking at changing how providers are paid to reward the investments in CPOE and safety.

Dr. Laiben interrupted the discussion at this point to praise Leapfrog for taking initiative. He pointed out that companies like Wal-Mart and Cosco never asked anyone to fund computerized inventory systems. Hospitals complain they don't have money to invest in safety, but there's always money to fund new construction. Competition (or lack of it) is a common denominator. If beds are full, there's no need to invest in safety. Unless someone stimulates the industry to change, it never will. LEAPFROG has taken this role. The medical industry has a lot of gall to say LEAPFROG can't tell "us" how to improve safety when it's clear that the industry can't or won't drive change. When trade associations protect the status quo, consumers must drive change. NCQA, JCAHO, CMS and similar organizations are all on Leapfrog's bandwagon. LEAPFROG has every right to set standards. The medical industry clearly won't do it voluntarily.

Dr. Laiben asked if it wouldn't be helpful for LEAPFROG to use a concept of peer pressure and peer feedback, as Vanderbilt has done?

A: LEAPFROG has clinician "lily pads" to leverage the power of peers with one another. Physician leaders are always needed. While many doctors are privately supportive of Leapfrog's efforts, nominations are always welcome for leadership in this area.

Comment: Reward is usually based on product. The medical community would buy-in to Leapfrog better if desired outcomes were stated and providers were allowed to come up with their own solutions on how to reach the outcomes.

A: Agree, but the outcomes data just isn't there. LEAPFROG would be happy to work with any provider that has standardized outcomes, but each provider always wants to use their own outcomes. There is no standardization.

Comment: Computerized medical records rely on systems that talk to one another. CPOE has to be the icing, and integrated systems have to be the cake. Integrated systems are a significant hurdle that must be crossed first.

Dr. Laiben asked the Commission, how is this issue reconciled? The medical industry spends money on new medical technology all the time. Why not on this?

Mr. Schoenhard volunteered that business administrators know enough disaster stories to make them cautious. A great deal of transformation is required in clinical processes. SSM sees this as not a technology issue but as delivery transformation. Failure to see it this way wastes money. There are a few fantastic examples of where it works, but vendors inflate their successes. If you mess it up, docs will be more resistant the next time you try.

Dr. Laiben pointed out that Kansas City is the hometown of Cerner Corporation, a major vendor of computerized medical systems. Yet no Kansas City hospitals have adopted CPOE. When is the target date for getting CPOE done? How does the medical industry drive the adoption of CPOE?

Nancy Kimmel offered that, although Missouri Baptist has systems that are not integrated, CPOE will take an enormous effort. Docs have to agree to protocols that can be loaded into the CPOE system.

Dr. Laiben reiterated that the commission's job is to tell Governor Holden what to do to improve safety. **Is a recommendation to have CPOE in all hospitals in 10 years the right amount of time? If not, what is the right time frame?** An open-ended recommendation is not a good benchmark. We fail the Governor if we can't apply the knowledge and expertise on the commission to this issue. If we don't, someone else will. The medical profession abdicates authority too frequently. We gave our business practices to hospitals and then to managed care. When do we decide for ourselves what's right?

**Nancy Kimmel responded by asking why would a recommendation regarding CPOE in any number of years be a good recommendation when we know that other steps must be done prior to this implementation?**

Dr. Laiben thought this was a valid point and asked what steps should come first and when should *they* come?

Mr. Schoenhard pointed out that a third of Missouri hospitals lose money every year, a third break even and only a third see any profit. How do hospitals pay to *learn* how to implement CPOE or integrated systems?

Dr. Laiben felt this was also a valid question. However, compare medicine to other industries, such as banking. ATM systems are worldwide, but two doctors in the same room can't agree on a treatment. The government relies on medical professionals to lead improvement efforts. We fail if we spend our time picking apart every suggestion for improvement.

**Mr. Schoenhard suggested that the commission should be wary of unfunded mandates.**

Dr. Laiben agreed and further stated that the commission must be the ones to know the value of each mandate. To repeat, no one paid Wal-Mart to computerize their systems. In medicine, no one has taken charge to move the industry in the right direction.

It was suggested that Leapfrog should acknowledge alternative goals pursued by hospitals. Ms. Probst agreed and also noted that Leapfrog is currently having an annual open comment period. She stated she would take comments of the commission about acknowledging improvement efforts whether they are Leapfrog's or not and pass them along.

Comment: There is a need for group learning. UMC Hospital went through this. Standard definitions are important. It would be good if CMS, Leapfrog, JCAHO and NCQA all agreed on the same standards. Also, Leapfrog needs to look at faster ways that improvements can be made. Technology adoption is a long way off, and other things can be accomplished in the mean time.

A: Leapfrog and JCAHO are working together closely. As to the last comment, LEAPFROG recommends looking at best practices that are easier to implement than CPOE, and offers information about best practices on their website.

#### IV. DRAFT TOPICS AND GUIDING PRINCIPALS

- Kathryn Nelson distributed another draft of Guiding Principals. She noted that a statement regarding public/private partnerships still needed to be added. Linda Bohrer distributed example guiding principals from other safety organizations.
  - **Dr. Morris also asked for a definition of the phrase "culture of patient safety".** He expressed frustration that this phrase is used so much it becomes a platitude. It may be that not everyone agrees on what this means. Kathryn agreed to work on a definition for this phrase.
- The results of ranking important topics by how the Commission can impact them were distributed. Kathryn asked the Commissioners to also rank these issues on importance.
- For both, Commissioners were asked to continue to send their thoughts and suggestions.
  - The Commission discussed whether topics should be ranked in order, or by using a 1-to-5 scale. It was decided to rank topics in order. Dr. Morris asked if results from last meeting and this meeting could be emailed. It was agreed MDI would do this, and would also make sure that members not in attendance today would be sent a copy and asked to vote.

Due to concerns about bad weather and driving conditions, the meeting was adjourned at 2:40 PM.